



REDUCTION IN TOBACCO ADDICTION

Training Manual

**A guide for health professionals providing
smoking cessation interventions for patients in
hospital and out-patient settings.**

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Preface

It is generally acknowledged that smoking is the single most preventable cause of death and disability. Altogether, smoking related costs to the NHS annually, involving cancer, respiratory, circulatory and digestive disease groups have been estimated to be about £1.5 billion (Parrot et al., 1998). In response to this, one of the goals of “Smoking Kills: A White Paper on Tobacco” (Secretary of State for Health, 1998) was the reduction of tobacco related diseases, especially cancer and coronary heart disease.

Hospital settings are ideal to raise the issue of smoking with smokers. Most smokers coming into hospital will have to cope with smoking restrictions and will not be able to smoke normally. They may be admitted for a smoking-related disease or a procedure that requires them to stop smoking. Thus being in hospital presents smokers with an opportunity to evaluate their smoking and perhaps think about giving up.

The Reduction in Tobacco Addiction (RETAD) Programme was a multi-centre, multi-setting project investigating the effectiveness and cost effectiveness of smoking cessation interventions for hospital patients. One aim of RETAD was the development of a template for delivering interventions in an everyday hospital setting in conjunction with existing smoking cessation services. This training programme has been designed to compliment the service delivery template.

The RETAD programme was funded by Department of Health and the authors are grateful for the specific guidance provided by Monty Keuneman, John Tiley, Mohammad Haroon and Janet Whybrow. In addition, the authors wish to acknowledge the contribution of the late Professor Arthur Crisp, Emeritus Professor of Psychological Medicine at St. George’s Hospital Medical School, for the support and advice he gave throughout the programme, particularly in his role as chair of the steering committee. Finally, the authors would like to acknowledge the support and contribution of their collaborators on RETAD programme. These include Ms. Hilary Andrews and Dr. Martin Grimmer from The Ipswich Hospital NHS Trust and Dr. Roger Bloor and Professor Illana Crome from North Staffordshire Combined Healthcare NHS Trust.

Professor Hamid Ghodse – Director of the International Centre for Drug Policy (ICDP)

- December 2008

Introduction

Overall Aims

The aim of this training programme is to provide in-depth guidelines regarding the training of health care professionals in the provision of smoking cessation interventions as part of their routine work in hospital settings. The training is suitable for a wide range of professionals, including nurses, social workers, occupational therapists, psychologists, pharmacists and medical practitioners. It is assumed that the trainers delivering this programme have received formal training in smoking cessation and motivational interviewing techniques.

Interventions have been designed at both basic and more intensive levels, and are aimed at patients using hospital services as either in-patient or out-patients. The programme is not aimed at supporting those patients already engaged in a quit attempt. Rather, its focus is on individuals who either are not contemplating quitting at all, or for who quitting is desirable but not something they are currently planning to attempt.

Key Learning outcomes and competencies:

On completion of the training programme, trainees will have developed:

- An in depth knowledge of the prevalence and impact of smoking.
- An awareness of the value of cessation to individuals and the population.
- Knowledge of the need for, and the range of pharmacological therapies.
- An understanding of the range and theoretical background of prominent psychological approaches to cessation.
- A knowledge of national smoking cessation guidelines and policy regarding smoking cessation.

- A good working knowledge of the evidence base and implementation of brief smoking cessation interventions, including patient assessment, advising, assisting and referral.
- A good working knowledge of intensive intervention, including basic communication skills and motivational interviewing techniques.
- The ability to apply both forms of intervention in the context of a range of circumstances, including patient indifference and aggression.

Overview

1.1

The training programme is divided into four major sections. Section one provides a background to the issues surrounding smoking, health and cessation. The aim of this section is to provide clinicians with an appropriate knowledge base that can be drawn upon when addressing the issue of smoking with patients.

Section two is concerned with the delivery of brief smoking cessation interventions. Brief assessment and advice regarding smoking are potentially an important element of all clinicians' work. This training programme provides a structured approach to brief intervention that can be delivered quickly and effectively as part of routine patient contact.

Section three provides a framework for more intensive smoking cessation interventions. Utilising a person-centred yet directive approach, the intensive intervention allows exploration of the individual patient's perspective on smoking and cessation. Drawing on motivational interviewing techniques, ambivalence is highlighted and resolved within the context of a non-confrontational, empathic interaction style.

In section four, a framework for skill rehearsal and development is presented. Trainees are able to explore the techniques employed in both forms of intervention across various situations and contexts. Through the use of examples (demonstrated on video and by the trainers) as well as role play, issues such as aggression and indifference are covered, leaving the trainee feeling more confident in their ability to apply the skills in a real-world setting.

Guidance on Delivering the Training Programme

This training programme is designed to allow flexibility in its application. Groups of trainees will vary in terms of knowledge, skills and experience and trainers may wish to spend more or less time on specific sections accordingly. For example, the section on communication skills may require greater emphasis within groups of trainees with little or no counselling training, while the issues covered in section one may require less time and discussion in groups of trainees familiar with this knowledge base from previous courses.

In every section, lecture based content is presented and followed by points for discussion or other group exercises. The lecture content is cross referenced to specific slides within the Microsoft Power-Point presentations accompanying the training pack (indicated in a grey box to the right of the text). These slides contain structured bullet points that trainers may expand on using the notes in the manual together with their own knowledge and experience. The discussions and group exercises are designed to consolidate learning by drawing upon the personal and professional experiences of the trainees. Trainers can maximise the value of these sessions by finding the right balance between allowing ideas to flow and maintaining a focus on the issue being discussed.

The training programme has been designed to be conducted across one full working day. Extensive time should be allowed for the section four as it draws together work from the previous parts of the course. Allowing sufficient time for the examples and role play is likely to greatly enhance the confidence of trainees in their ability to apply what they have learned.

It is recommended that two trainers are present during the delivery of the final section. This enables one trainer to take part in a role played intervention (acting as either patient or interventionist) leaving another able to observe and comment on the interaction that takes place. The availability of two trainers also facilitates effective observation of trainees' progress in larger groups. The recommended number of trainees in a group is between 4 and 10.

The delivery of section four also benefits greatly from utilising the recommended video segments for illustration of techniques. The videotape referred to in this training programme is “Health Behaviour Change – A Selection of Strategies: An Aid for Trainers” produced by the Media Resources Centre, University of Wales College of Medicine (2001).

Additional resources should be provided by the local training team concerning local smoking cessation services. These may include leaflets and booklets, service location maps, opening times and contact details. It is recommended that these be given to trainees before section two.

Sample Timetable for Training Day

09:00	Introductions
09:30	Section 1: Smoking and Health
11:00	- <i>Break</i> -
11:15	Section 2: Brief Interventions
12:00	- <i>Lunch</i> -
13:00	Section 3: Intensive Interventions
14:30	- <i>Break</i> -
14:45	Section 4: Intervention Delivery
17:00	End

Ongoing Monitoring and Evaluation

The degree to which individual trainees’ competence can be evaluated and enhanced within the training programme is limited. This is because strengths and weakness may only become apparent once the trainee has been applying the intervention in a real-life setting for some period of time.

There may be some value, therefore, in the establishment of an ongoing ‘refresher’ programme for trainees at a local level. Refresher sessions could be organised for trainees periodically by the training team, in which progress can be

evaluated, and support given that is focused towards individual trainees' particular needs. It would also be expected that trainees would be able to derive support from each other through discussion and feedback of issues that have arisen in their work with patients.

Trainers may also use the ongoing refresher sessions to conduct an evaluation of the programme as a whole. Quantitative data may be collected on the number and frequency of the interventions conducted, as well as the number of referrals to local smoking cessation services made and the uptake of NRT / Zyban. In addition, more qualitative assessments may be made of the issues that arise in the implementation of the programme.

Section 1

Smoking and Health

Session Aim:	To provide trainees with essential background knowledge regarding smoking, health and smoking cessation.
Learning Outcomes:	An in depth knowledge of the prevalence of and decline of smoking across society and within sub-groups. A knowledge of the impact of smoking on health and well-being. An awareness of the value of cessation, individually and on a population basis. Knowledge of the need for, variety of, and issues relevant to the use of pharmacological therapies. An understanding of the range and theoretical background of psychological approaches to smoking cessation.
Learning Activities:	Lecture; Group Discussion
Supporting Materials:	PowerPoint Presentation (RETAD training manual_1.ppt) Handout: Printout of slides with space for notes.

1.1 Prevalence of Smoking

Recent estimates, from the General Household Survey are that there are about 12 million adult cigarette smokers in the United Kingdom. In addition, there are around another 3 million people who smoke pipes and/or cigars (Office for National Statistics, 2002).

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There is little difference between the sexes in terms of smoking prevalence. However, there are differences in the rates of decline, in that while overall prevalence among adults (aged 16 and over) fell steadily between the mid 1970s and the mid 1990s, this decline was much greater among men than women.

It is clear that, while only a few young people are smokers when they start secondary school, the likelihood of smoking increases with age so that by age 15 22% of pupils are regular smokers. Smoking prevalence is highest in the 20-24 age group for both men and women (40% and 35% respectively); but thereafter in older age groups there are progressively fewer smokers. Smoking prevalence was lowest among people aged 60 and over, where 16% of men and 17% of women were defined as current smokers. There has been a marked decrease in prevalence rates among older people since the 1980s, for instance smoking rates in those aged 50-59 decreased from 44% to 25% in 2001. However a similar trend has not been found among younger people, as over the same period quit rates only decreased from 42% to 37% among those in the 20-24 age group (General Household Survey, 2002).

Smoking rates have been in decline since the Second World War. The highest recorded level of smoking among men was just over 80%, back in 1948. The slower rate of decline among women is clearly evident across this time period. Other differences are evident if social class is considered. There has been a slower decline in smoking among lower socioeconomic groups, so that smoking has become increasingly concentrated in these groups. In 2000, smoking prevalence remained over twice as high among people employed in manual occupations compared to those in professional positions.

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The Health Survey for England 1999: the health of minority ethnic groups (2001) shows higher rates of smoking prevalence among certain ethnic minority groups, for instance there are far higher levels in the Bangladeshi (44%), Irish (39%) and Black Caribbean male populations than in the general population. Irish women are also more likely to smoke than women in the general population, with 33% of women reported as currently smoking cigarettes. Prevalence rates for Black Caribbean women (25%) were similar to that of the general population, and smoking rates for women in other minority groups are fairly low, ranging from 1% in Bangladeshi women to 9% in Chinese women.

It has been estimated that people living with a mental illness are twice as likely as the general population to smoke (El-Guebaly & Hodgins, 1992). In terms of

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relative tobacco consumption, it was recently reported in a US survey that 45% of all cigarettes consumed were smoked by individuals with a psychiatric disorder (Lasser et al., 2000). While smoking rates among the general population are falling, this may not be the case for people affected by mental illness (McCloughen, 2003).

One explanation of the high prevalence of smoking is that many mental health patients may self-medicate with tobacco, taking advantage of the potential for nicotine to alleviate symptoms. For example, nicotine has been found to stimulate neurotransmitters (such as dopamine) in the same way as many anti-depressant medications may do (Le Houezac, 1998). Another theory is that the propensity to smoke among mental health patients is mediated by their social circumstances. Smoking has been found to be strongly associated with social deprivation (in terms of low income, poor accommodation, unemployment etc) (Jarvis & Wardle, 1999) and deprivation, in turn, is related to the existence of a psychiatric disorder (Rasul et al., 2001). More research is needed into the impact of social deprivation and unmet need on smoking among mental health patients.

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Despite their higher rates of smoking, smokers with mental health problems are motivated to quit. Recent surveys in the UK have reported that around 50% of people with mental health problems who smoke are concerned and want to stop (McNeill, 2001). Furthermore, despite commonly held assumptions to the contrary, studies of smoking cessation interventions indicate that they are as successful among mental health patients as they are among the general population (el-Guebaly et al., 2002). On this basis, there has been a call for more resources to be devoted to cessation efforts within this population and more effort on the part of clinicians to involve patients in cessation services. Indeed, collaboration between smoking cessation services and mental health services was an official recommendation in the recent Health Development Agency report “Meeting Department of Health Smoking Cessation Targets (HDA, 2003). However, psychiatric patients often feel excluded from such mainstream services (Lawn et al., 2002) and are often excluded from evaluations of outcome (Rigotti et al., 2003).

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1.2 The Impact of Smoking

Over 120,000 people in the UK are killed by smoking each year. This figure accounts for one fifth of all UK deaths. This translates as one in two long-term smokers dying prematurely (Health Education Authority, 1998). Six times as many die prematurely from smoking as from: road accidents, all other accidents, all illegal drugs and poisoning, murder, manslaughter and suicide *combined* (The World Bank, 1999).

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The effects of smoking go beyond the actual smoker. Passive smoking does cause lung cancer and appears to have a proportionately very high risk for heart disease: a passive smoker has about one quarter of the heart disease risk of a 20 a day smoker. Children are very vulnerable - 17,000 hospital admissions each year in the under-5s related to smoking. Another form of passive smoking is caused by smoking during pregnancy which can cause low birth-weight and other pregnancy complications.

Most smokers die from one of the three main diseases associated with cigarette smoking: lung cancer, chronic obstructive lung disease (bronchitis and emphysema) and coronary heart disease.

But not all smoking related illnesses are the well-known examples such as lung cancer; the risk to smokers is far more wide ranging. Other diseases smokers are prone to include Buerger's Disease (severe circulatory disease) and oral cancer, as well as Pneumonia; Crohn's Disease and Amblyopia (loss of vision).

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Group Discussion:

Despite the risks, why do so many people still smoke?

Ask trainees to come up with reasons from both their professional and personal experience. Also, address whether different people may smoke for different reasons (eg – young people; people in routine work).

Reasons may include:

- Lack of awareness of risks
- Addiction
- Control
- Social pressure
- Stress
- Anxiety

1.3 Smoking Cessation

Quitting by adult smokers offers the only realistic way in which widespread changes in smoking status can prevent large numbers of tobacco deaths over the next half century. Helping large numbers of young people not to become smokers could avoid hundreds of millions of tobacco deaths in the second half of the century, but not before. Widely practicable ways of helping large numbers of adult smokers to quit preferably before middle age, but also in middle age, might well avoid one or two hundred million tobacco deaths in the first half of the century.

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In 1990, both male and female former smokers had markedly lower rates of lung cancer when compared with continuing smokers. As a result of cessation, only about half of the predicted lung cancers actually occurred in 1990. The cumulative risks of lung cancer by age 75 were 10%, 6%, 3%, and 2% in men who quit at ages 60, 50, 40, and 30, respectively. Smoking cessation has created a gap between predicted and actual lung cancer rates in the United Kingdom; quitting, even well into middle age, has a protective effect (Peto & Lopez, 2001).

Despite the substantial decreases in the prevalence of cigarette smoking in some developed populations, there have been large increases elsewhere, particularly in Chinese males, over the past decade or two, and it is difficult to see how worldwide cigarette consumption can be halved over the next decade or two (Peto & Lopez, 2001).

Hence, the 100 million tobacco deaths in the 20th century are likely to be followed in the 21st century, if present smoking patterns persist, by about 1 billion tobacco deaths.

Not all the benefits of quitting smoking are long into the future. Smokers who quit may notice positive changes in their health almost immediately. These changes will be particularly salient to those who have been smoking for many years.

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By emphasising these benefits, and encouraging ex smokers to pay attention to them, we can enhance the extent to which they provide positive reinforcement of cessation efforts.

Group Discussion:

Besides health, what are the other benefits of quitting?

Benefits may include:

- *More disposable income*
- *Less pressure from family friends to quit*
- *Lack of smell in house / on clothing*
- *Sense of achievement and personal control*

Misconceptions are common among smokers regarding how the benefits described above can be achieved. In particular, patients may feel (and assert) that they may experience better health by cutting down on the number of cigarettes smoked or switching to low tar cigarettes. These misconceptions are discussed more fully in section 2 (see information on advising patients).

The benefits of quitting, while clear, need to be considered against the perceived benefits of smoking. This is an important consideration since the perceived benefits of smoking may well counterbalance the benefits of quitting in the minds of patients and act as a barrier towards cessation.

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One major benefit of smoking is the avoidance of withdrawal. Stopping smoking can lead to withdrawal symptoms such as: depressed mood; insomnia; irritability; anxiety; difficulty concentrating; restlessness; decreased heart rate; increased appetite or weight gain. Many smokers believe such symptoms are inevitable. However, they can be effectively controlled, particularly by the use of pharmacological supplements (described in the following section)

Another commonly perceived benefit of smoking is stress relief. However, smoking doesn't reduce stress. Stress is simply experienced when nicotine levels in the body drop, and as a result, the body starts craving for more. The lack of nicotine causes stress, as there is a need for another cigarette to top up the

nicotine levels in the body. Therefore, being a smoker won't relieve any stress in an individual's life, rather, it is likely to add to it.

A final perceived benefit of smoking is social desirability. This perception is most salient among young people, for whom smoking may bring status within a peer group. Smoking may be seen as demonstrating individuality, or a rebellious nature.

In consideration of the above 'benefits', it's clear that smoking is also a complex behaviour, and merely convincing smokers of the value of cessation will rarely be enough to bring about a successful quit attempt. Smoking is very addictive psychologically and pharmacologically. Both aspects need to be addressed if smoking cessation intervention is to be effective.

1.4 Pharmacological Approach to Cessation

1.4.1 Nicotine Replacement Therapy

Nicotine is one of the most frequently used drugs that can become addictive. Cigarette smoking results in rapid distribution of nicotine throughout the body, usually reaching the brain within 10 seconds of inhalation. Nicotine activates the brain circuitry that regulates feelings of pleasure. Smokers report that smoking aids concentration & performance, but also that it calms them down in times of stress.

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Withdrawal from nicotine involves symptoms that include headache, agitation, sleep disturbance, anxiety and a craving. A smoker's body develops a need for a certain level of nicotine at all times, and unless that level is maintained, he or she will experience withdrawal symptoms. Nicotine withdrawal symptoms peak 48 hours after quitting and very rarely last beyond a few months.

Nicotine Replacement Therapy (NRT) can aid smokers quit by alleviating some of the symptoms associated with withdrawal. The aim is to replace the nicotine inhaled from smoking cigarettes by other, safer methods of delivery, thus reducing

craving and withdrawal. Unlike tobacco smoke, it does not contain tar and carbon monoxide or the other toxic substances found in tobacco. It only contains nicotine and there is no evidence yet that nicotine causes cancer.

Research findings point to the effectiveness of NRT in helping smokers quit. A recent review of the literature found that the odds ratio of smoking cessation of any NRT versus placebo was 1.74. In terms of percentages of smokers quitting, the average over all trials shows that about 10% had not smoked for the 12 months following placebo therapy, and about 17% had not smoked following NRT (National Institute for Clinical Excellence, 2002).

There are currently six different types of NRT products manufactured and the companies are developing more formulations. Currently NRT is available in the form of gum, patches, nasal spray, sublingual tablet, inhalator and lozenges. As yet there is no controlled trial evidence favouring any one of these NRT products over another. Since they have similar success rates, the choice between them is a practical and personal one. Oral products permit more personal control over the dosage and can be helpful for smokers with an irregular pattern of smoking. Alternatively the patch delivers a fairly consistent dose of nicotine and is therefore more suitable for people with a regular pattern of smoking.

The **nicotine patch** is most suitable for smokers who have a regular pattern of smoking since nicotine delivery is continuous for the time that the patch is worn. There are two types of patch; 16 hour and 24 hour. The 24-hour patch can be useful for the control of cravings on waking, or for people who smoked in the night, but a continuous dose of nicotine can cause sleep disturbances in some people. In contrast the 16-hour patch is not worn overnight but is replaced each morning. The nicotine free period over night can reduce sleep disturbance. Each patch is available in three strengths, which are intended to be used in a gradual step down process. The recommended time for using a patch is 12 weeks. Occasionally the patches can cause local skin irritation, although this can pass after a few days. It is important to rotate the site of the patch daily. The patch offers a discreet method of nicotine delivery and is most helpful for a smoker with a low behavioural dependence on cigarettes.

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Nicotine gum comes in 2 mg or 4 mg doses and in a variety of flavours. It is essential that the gum is used in a “chew-rest-chew” technique. The manufacturers recommend this as any nicotine that is swallowed is wasted and can cause unpleasant side effects. The correct technique is to chew the gum slowly to release the nicotine and once the taste becomes strong chewing should stop. This allows the nicotine to be absorbed through the oral mucosa. The gum should then be “parked” between the gum and cheek, and when the taste has faded it should be chewed again. The 2mg gum is most effective for smokers of 20 or less cigarettes per day and for those who smoke more than 20 cigarettes per day the 4mg gum is most appropriate.

Nicotine nasal spray is a small bottle of nicotine solution, which delivers a dose of nicotine in a liquid spray to each nostril. Nicotine taken in this way is absorbed faster than from the other products and may suit more addicted smokers. It is recommended for smokers of more than 20 cigarettes per day and/or for those who light up within thirty minutes of waking. This product can cause local irritant effects such as runny nose, sneezing, throat irritation. These side effects should lessen with use, usually after a few days.

The **nicotine inhalator** consists of a plastic mouthpiece, into which is inserted a cartridge of nicotine. Smokers draw on it like a cigarette. Despite its name, the nicotine does not reach the lungs, but is absorbed via the oral mucosa. This product is most appropriate for smokers of 20 or less cigarettes a day. It is a unique form of NRT as it addresses both the physical and behavioural aspects and is therefore particularly useful for smokers who miss the hand-to-mouth activity of smoking.

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The **nicotine sublingual tablet** delivers a 2mg dose of nicotine which when placed under the tongue dissolves gradually within 30 minutes. The nicotine is absorbed via the oral mucosa. This product can be used for both high and low dependency smokers by using either 1 or 2 tablets per dose. It should not be sucked, chewed or swallowed as this prevents the absorption of nicotine.

The **nicotine lozenge** is available in three different strengths 1mg, 2mg, and 4mg. The 1mg lozenge is most effective for smokers of 20 or less cigarettes per day. The 2mg lozenge is most suitable for smokers who smoke after 30 minutes of waking up. The 4mg lozenge is most appropriate for smokers who normally smoke within 30 minutes of waking up. The technique for using the lozenge is the same for all strengths. The lozenge should be sucked until the taste becomes strong. It should then be parked between the gum and cheek until the taste has faded. It should then be sucked again. This “suck and park” technique should continue until the lozenge has dissolved completely.

1.4.2 Bupropion (Zyban)

Bupropion (Zyban) is a non-nicotine smoking cessation aid which is licensed as a prescription only drug. It is recommended for use with motivational support in nicotine dependent patients. This drug has been used extensively in the USA as an antidepressant for a number of years under the trade name Wellbutrin. Research has confirmed that it is an effective treatment for tobacco dependence. The twelve month continuous abstinence rate was 23% in one comparative clinical trial. The exact mechanism of action is unclear but, as with NRT, cravings are reduced. Unlike NRT the smoker continues to smoke for the first week of treatment. Medication is increased from 150 mg to 300 mg daily on the seventh treatment day. Remaining on the lower dose throughout treatment is recommended for older patients and those where there may be special precautions.

The full course of bupropion lasts for eight weeks. The use of bupropion is associated with a dose – dependent risk of seizure (fits) of 0.1% (1 in a 1000). Bupropion is contraindicated for patients with a history of seizures, those suffering from bulimia or anorexia nervosa and in patients on monoamine oxidase inhibitors and those on Wellbutrin (contains bupropion). It is contraindicated in those with head injury or cerebral tumour, severe liver disease or those withdrawing from diazepam or alcohol. Special precautions are also needed when the patient is taking other medications which may lower the seizure threshold. These include antidepressants, antimalarials, antipsychotics, theophylline, oral hypoglycaemics,

insulin and systemic steroids. Seizure threshold may be reduced in those taking over the counter stimulants and those addicted to cocaine or opiates.

There have not been any studies using bupropion in pregnancy although animal studies have not shown evidence of harm to the foetus. Women should not take bupropion whilst breastfeeding.

Bupropion use is associated with minor side effects such as dry mouth, insomnia, drowsiness, skin disorders and nervous system disturbances such as headache and dizziness. Adverse event reporting has been in line with expected incidence of side effects. It is thought likely that deaths associated with the product are likely to be due to tobacco related disease. The prescribing of bupropion, as with many drugs, involves a risk/benefit assessment. It must be remembered that tobacco dependence kills half of all regular smokers and smoking cessation for those not already ill may be life saving.

Group Discussion:

What are the advantages of NRT / Zyban? What may be some disadvantages to be aware of?

Advantages:

- *Reduce withdrawal symptoms*
- *Safe and non-addictive*
- *Use may reinforce efforts to quit*
- *Usually prescribed along with additional advice*

Disadvantages:

- *Don't really combat behavioural addiction (habit)*
- *Nicotine absorption different from cigarettes (NRT)*
- *Adverse drug interactions (Zyban)*
- *May shift focus away from the need for will power*

1.5 Psychological Approach to Cessation

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Being addicted to nicotine is the key reason why smokers find it hard to stop. The addiction involves not only physical dependence on the drug nicotine, but also psychological and emotional dependence on smoking as a means of coping with stress, boredom, anxiety or anger. Smoking soon becomes an automatic habit that contributes to the difficulties smokers experience when trying to give up. Hence removing the prop, in this case the cigarette, without developing a replacement can quickly lead to relapse.

Following a biopsychosocial approach to health and illness, we know that health is also a function of psychological processes as well as the social environment. We can't adequately approach any aspect of health in a purely biological way. This is especially true of addictions.

Many psychological techniques have been applied to the issue of smoking. These include behavioural therapies (eg – aversion therapy) as well as cognitive behavioural methods. In practice, most psychological therapies will involve some sort of synthesis of different approaches

1.5.1 Behavioural Therapies

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Addictive behaviours can be seen in the same way as any other behaviours. They are learned through interaction with the environment and other individuals. In this way, they may follow basic rules of conditioning. From a Classical Conditioning perspective, smoking may become associated with times of relaxation (eg – over a coffee or in the pub). Over time, the pairing of smoking and feelings of relaxation may lead to smoking becoming a conditioned stimulus and producing relaxation in itself. In terms of Operant Conditioning, many children start smoking at school in order to be accepted. Smoking may be positively reinforced by social acceptance. It may also be negatively reinforced by the potential for withdrawal caused by cessation. Also important in the learning process may be social modelling. Many people will start smoking if they observe significant others (such as parents or celebrities) smoking. This is one reason why smoking is often excluded from TV programmes and films.

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There have been several behavioural therapies for smoking cessation employed over the years. Aversion Therapy aims to pair a negative stimulus with smoking so as to create a different (negative) conditioned response. One extreme example has been 'rapid smoking', which involves smoking in a closed room rapidly (one puff every 6 seconds) thus creating very unpleasant effects (eg – nausea). The effectiveness of this method comes from the pairing of smoking is paired with unpleasant stimuli. There are of course many negative side effects, including increased CO levels and heart rate. Another behavioural method, Contingency Contracting, provides reinforcement of cessation through the social influence of a contract with a therapist or significant other. Contracts are established with the smoker that employs monetary rewards for not smoking and monetary punishments for smoking.

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1.5.2 Cognitive Behavioural Therapy (CBT)

CBT is a psychological intervention that emphasizes the important role of how we think about things. Based upon cognitive theory, it assumes that human beings, rather than simply reacting to the world around us in a predictable way, interpret what we see and hear according to previously developed beliefs and attitudes. This interpretation will, in turn, influence how we react, both mentally, and behaviourally.

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Social Cognition models have been developed and used to examine various aspects of health related cognitions in order to predict future health behaviour. Beliefs surrounding the risks of health behaviour, susceptibility to illness and perceived control over one's behaviour may all predict whether someone will attempt and / or succeed in changing their behaviour.

There are several approaches to cognitive-behavioural therapy, all of which differ to some degree. These include Rational Emotive Behavior Therapy, Rational Behavior Therapy, Rational Living Therapy, Cognitive Therapy, and Dialectic Behavior Therapy.

All cognitive behavioural therapies share three fundamental propositions. These are that, first, cognitive activity affects behaviour. Second, it is asserted that

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cognitive activity may be monitored and altered. Third, the conclusion is that desired behaviour change can be affected through cognitive change.

1.5.3 Stage of Change and Motivational Interviewing

1.26

Work done by clinical psychologists Drs Prochaska and DiClemente has shown that stopping smoking is not a single event, but a process during which the smoker goes through a series of stages. Although experts disagree on the extent to which this model holds true for all smokers, it is a practical model, particularly, as it draws attention to the fact that the standard advice “you should stop smoking and here’s how you do it” is wasted on many “contented” smokers.

The Stages of Change model is an attempt to describe readiness and how people move towards making decisions and behaviour change in their everyday lives. This model provides useful guidance to practitioners on different ways to approach smokers.

- Pre-contemplation stage (contented smokers): No interest in changing behaviour and see many personal advantages in the habit.
- Contemplation stage (considering changing): Thinking about changing and acknowledging some dangers and risks. They may still have many reasons for continuing.
- Preparation stage: Thinking that stopping is personally beneficial. Believing that stopping is possible and making definite plans to stop.
- Action stage: Changing usual behaviour (eg – quitting smoking).
- Maintenance: Staying stopped and coping with relapse.
- Relapse: Can occur at any time during movement through stages.

Smoking is a complex habit and in order to stop, a person must deal with their addiction to nicotine and the psychological and social aspects of the habit. No two smokers will make changes in exactly the same way. Prochaska and DiClemente noted that a person's attitude changed before the behaviour changed and that relapse was a common feature of the process. Providing factual information on the dangers to health may increase a patient's knowledge, but there is little evidence that this will help them change.

Movement through the stages is not always in one direction. Individuals, when quitting, may move back through the changes (eg – relapse) as well as forward. They may also skip stages.

Existing NHS stop smoking services will come in to contact with those individuals quite concerned about their smoking, and who at the very least are contemplating change. They will, however, miss those for whom quitting is not on the agenda. The RETAD Programme overlaps with these services in that the interventions are aimed at contemplators. However, the interventions covered in this training programme also fill an important gap by engaging pre-contemplators.

1.27

Motivational Interviewing evolved from the work done with problem drinkers by Miller in the early 1980's. The basic concepts outlined by Miller were then developed and applied more generally by Miller and Rollnick in the 1990's along with a more detailed description of the clinical principles underpinning the model. Since then there has been a great deal of research evidence amassed to support the clinical application of Motivational Interviewing across the range of 'problem behaviours' such as alcohol abuse, drug use, and more generally in the field of behaviour change. One of the more recent advances is the application of the model to smoking and smoking cessation interventions.

1.28

Miller and Rollnick define Motivational Interviewing as a '*Directive client-centered counselling style for electing behaviour change by helping clients explore and resolve ambivalence*', Miller & Rollnick (1995). In contrast to non-directive counselling with which it shares some characteristics it is more focused and goal-directed. In the case of smoking, the approach is focused on the ultimate goal of

abstinence. The role of the advisor is to intentionally examine and explore the smoker's ambivalence to change and to highlight the smoker's ambivalence, and to elicit self-motivating statements.

Group Discussion:

Which psychological factors will influence whether someone is a pre-contemplator or a contemplator regarding quitting smoking?

Factors may include:

- *Perceived risks of smoking*
- *Perceived severity of smoking related illnesses*
- *Perceived social desirability of smoking (eg – cool vs disgusting)*
- *Perceived consequences of quitting (eg – better breathing vs weight gain)*

Section 2

Brief Interventions

Session Aim:	To provide trainees with the knowledge and skills essential for the delivery of a brief smoking cessation intervention.
Learning Outcomes:	A knowledge of the evidence base concerning brief smoking cessation interventions and their place within national cessation guidelines An awareness of patient assessment in terms of smoking status, motivation to quit, readiness to change and nicotine dependence. An awareness of the issues surrounding advice giving, including the importance of addressing common misconceptions. An understanding of ways to assist patients through the discussion of pharmacological and psychological / behavioural support options. An awareness of the need to move patients on in terms of a referral or provision of service information.
Learning Activities:	Lecture; Group Discussion
Supporting Materials:	PowerPoint Presentation (RETAD training manual_2.ppt) Handout: Printout of slides with space for notes. To be provided by trainer: Information on local smoking cessation services (eg – leaflets, contact details).

2.1 National Smoking Cessation Guidelines

Back in 1999, following the publication of a comprehensive strategy to tackle the impact of smoking on health ('Smoking Kills': A White Paper), the government produced a new guide for health professionals entitled *Helping Smokers Stop: A new approach for health professionals* (Health Education Authority 1999).

These guidelines were the first of their kind in the history of the NHS. They were intended as a clear guide for all health professionals on how they can give

practical advice, help and support to the 70 per cent of smokers who want to give up smoking.

The guidelines were reflected in recommendations published in the journal *Thorax* as part of the article *Smoking cessation guidelines for Health Professionals* (West, McNeill & Raw, 2000). These recommendations included the view that, where practicable, current smokers attending hospital should receive opportunistic advice from clinicians. This should be during routine consultations and include the offer of a prescription for NRT or bupropion and further support by way of a referral to a specialist clinic or other specialist service. Clinicians were advised to record the response to advice, and arrange follow up where appropriate.

2.2 Brief Interventions: Evidence Base

Evidence suggests that advice from clinicians to their smoking patients could be effective in facilitating smoking cessation. The results of a systematic review of previous studies by Silagy & Stead (2001) confirmed that brief advice from clinicians is effective in promoting smoking cessation. The effect of even a very brief intervention by a health professional equated with a difference in the cessation rate between those who received advice from a clinician and those who did not of about 2.5%. This means that, based on quit rates amongst smokers, there would be one extra quitter as a result of minimal intervention from a physician for every 40 people who receive such advice.



2.3

This may not sound like a particularly high success rate. However, we have to view the wider picture. From a public health perspective, even if the effectiveness of supporting smoking cessation by clinicians is small, the net effect on reducing smoking rates could still be very significant if the smoking cessation efforts are widespread (Chapman 1993). Brief advice could translate into a substantial public health benefit if consistently provided, as approximately 80% of adults have contact with a health care practitioner, usually in primary care, at least once each year (Silagy 1992).

Group Discussion:

Do trainees currently advise patients about smoking on a routine basis? If yes, in what form? If no, what may be preventing them?

Issues may include:

- *The nature of advice given*
- *Time limitations*
- *Fear of an adverse effect on relationship with patient*

2.3 Delivering a Brief Intervention

The brief intervention outlined in this training programme has a number of aims. Overall, the aim is to raise the issue of smoking with patients and move them on in terms of thinking about quitting. This may not have been done for some time and patients' reactions to a clinician raising the issue will vary greatly.

2.4

The first specific aim within a brief intervention is to ask questions and assess the patient's smoking status and stage of change. In particular, it is helpful to determine whether the patient is a pre-contemplator (ie – a non-concerned smoker) or a contemplator (a concerned smoker who wishes to quit). This in turn will influence the second aim of the brief intervention, which is the giving of information and advice on smoking. Within the intervention there is scope for increasing patients' awareness of the health risks of smoking as well as the benefits of quitting.

The intervention does not stop at advice giving, however. The third aim is to provide assistance to the patient regarding quitting. One important way of doing this is informing patients about the support that is available to them in the form of NRT or Bupropion. The final aim of the brief intervention is to, if appropriate, help the patient progress to the next stage of the quitting process. This may include arranging a referral to local stop smoking services.

This whole process can be summarised in the 'Four A's' approach:

- ASSESS** - smoking status and stage of change
- ADVISE** - on the dangers of smoking and the benefits of quitting
- ASSIST** - concerning NRT, Zyban and other support for quitting
- ARRANGE** - contact with local cessation services

By the end of this process patients will have established a rapport with you, be aware of their smoking status and stage of change, and be aware of the role and range of support available for smoking cessation. In some cases, although not in all, patients may also be more motivated to quit and even nearer to taking the first practical step in the quit process.

The next four sections will look in depth at the four stages in the brief intervention process and consider how these may be dealt with in a way that maximises the effectiveness of the intervention. The flow chart on the next page is provided only as a guide. It is important that you cover all the elements of the intervention but it does not have to be in a very rigid fashion. The patient will dictate the pace and content of the discussion at times and you should try and go with the flow but also make sure that all topics are covered. This will take some practice before it becomes more natural.

Basic Intervention

ASSESS

How long have you smoked cigarettes?
How many cigarettes do you smoke per day?

Q: Have you ever tried to give up?
Q: Are you thinking about giving up?

Assess Stage of Change

ADVISE

- Advise patient to quit smoking
- Explain the risks of smoking
- Explain the benefits of stopping

ASSIST

- Discuss the use of NRT / Zyban
- Discuss smoking cessation services

ARRANGE

- Refer to Stop Smoking Service?
- Give Leaflets etc on services
- Answer any final questions

2.4 Assess

2.5

To ask your patient about their smoking status, ask questions like: How many cigarettes do you smoke per day? How long have you been a smoker? These questions don't just confirm that the patient is still smoking, but also give an idea as to the extent of their smoking and the place smoking occupies in their life (eg – they may be a 'chain' smoker or 'social' smoker).

From this point, the issue of whether the patient has ever tried to quit can be explored, and from there, how they feel about trying to quit in the future. The patient's Stage of Change will usually become clear in that some patients will express concern over their smoking and a wish to quit (contemplator) or whether they are quite content with smoking and not interested in change (pre-contemplator). It should be noted that a contemplator, although concerned about their smoking, may not express any intention to give up in the near future.

As an aid to assessing patients' stage of change, the following chart can be used.

Readiness to Change Scale	
10	Taking action to quit (e.g. cutting down, enrolling in a quit programme)
9	
8	Starting to think about how to change my smoking patterns
7	
6	
5	Think I should quit but not quite ready
4	
3	
2	Think I need to consider quitting some day
1	
0	No thought about quitting

It is also recommended that patients' readiness to change is assessed. This can be done assessed by asking patients to rate themselves (say from 1 to 10) on two simple scales. First, they should be asked to rate how importance quitting is for them. Second, they should be asked to rate their confidence in being able to quit if they tried. Readiness to change, as a function of importance and confidence, is discussed in detail in the intensive section later on in this training programme..

Another important question at this stage concerns the patient's willingness to access smoking cessation treatments. Their willingness to use NRT / Zyban

should be assessed, as well as their attitude towards smoking cessation services. Again, patients can be asked to rate their willingness to access such support on a ten point scale. Just getting your patient to evaluate which stage they are at will be valuable for the patient and the person conducting the intervention. For the latter, it indicates where the patient is at, thus guiding whether subsequent emphasis should be placed providing advice on the dangers of smoking or on assistance regarding the quit process and the support available (see next two sections). For the patient, it facilitates reflection on their status and reasons for being at that stage.

A final aspect of a patient's smoking that may be utilised is nicotine dependence: Having an idea of this will inform the potential for pharmacological treatments, which can be discussed later with the patient. Dependence can be assessed using the following brief scale (developed by Professor Karl Fagerstrom). The greater the patient scores, the higher the level of nicotine dependence. A score of 5 or more indicates high dependence:

- 1. How soon after you wake up do you smoke your first cigarette?**

After 60 minutes	0
31 – 60 minutes	1
6-30 minutes	2
Within 5 minutes	3
- 2. Do you find it difficult to refrain from smoking in places where it is forbidden?**

No	0
Yes	1
- 3. Which cigarette would you hate most to give up?**

The first in the morning	1
Any other	0
- 4. How many cigarettes per day do you smoke?**

10 or less	0
11- 20	1
21-30	2
31 or more	3
- 5. Do you smoke more frequently during the first hours after awakening than during the rest of the day?**

No	0
Yes	1
- 6. Do you smoke if you are so ill that you are in bed most of the day?**

No	0
Yes	1

2.5 Advise

2.6

Although numerous public health campaigns over recent years have raised awareness of the risks of smoking, patients will vary in terms of how much they know about these risks, as well as how much they know about the benefits of quitting.

In delivering the brief intervention, therefore, it may be useful to precede any advice by checking the patient's current knowledge. This will not only guide the information giving section of the intervention, but also highlight any misconceptions that a patient may have (eg – “you need to have been smoking for many years to get cancer” or “smoking low tar cigarettes is safe”). These misconceptions, if they arise, may provide a useful focus for the advice given.

So-called "low-tar" cigarettes only seem that way in machine tests. People don't smoke like machines. They smoke low-tar cigarettes more aggressively than high-tar cigarettes, inhaling more deeply and smoking more cigarettes. In fact, research by the American Cancer Society shows that smokers today face a higher lung cancer risk than do smokers before the dawn of "light" cigarettes.

Equally, cutting down is not a recommended route for smokers. There is no safe level of tobacco consumption. Furthermore, it is likely that smokers who limit the number of cigarettes they have per day will smoke consume more of each the cigarettes they do smoke (ie – smoking right down to the butt and taking more puffs). Cutting down is also not really a sensible option since most smokers find that the number they smoke soon creeps back up again to the original level.

Aside from countering misconceptions, the aim of this part of the intervention should be to make the information given as personal to the patients as possible. For example, if a patient suffers from asthma, the dangers of smoking for the respiratory system may prove a useful focus. Equally, if a patient has young children, then the dangers of passive smoking may be worth highlighting.

At this point, it is important to bear in mind that the purpose of the intervention is not to harass the patient into quitting. Advice given in a harsh, accusing manner will inevitably lead to a patient becoming defensive and greatly reduce the

effectiveness of the intervention. Rather, information should be given in a way that is positive, and that emphasises the benefits of quitting as much as the dangers of smoking. The information presented in section one of this training programme on both the long and short term benefits of stopping smoking may prove a useful tool at this stage of the intervention.

Group Discussion:

What are the benefits of quitting? Without referring to notes from section one, how many benefits can trainees recall?

This review should cover:

- *Long term benefits (eg – risk of cancer)*
- *Short term benefits (eg – improved breathing)*
- *Non-health benefits (eg – financial, social)*

2.6 Assist

Many patients, despite being concerned about their smoking and the associated risks (ie – contemplators), do not feel ready to quit. They may simply not believe that they can do it. Patients can be helped to move forward, however, by highlighting the support that is available for those wishing to quit smoking.

2.7

A major form of support for those quitting smoking is pharmacological. As discussed earlier in this training programme, NRT and Bupropion can greatly enhance the likelihood that an individual attempting to quit smoking will succeed. Patients may be unaware of the range of NRT products that are available. Thus, particularly in the case of concerned smokers, a discussion of the various options, as well as how they can be obtained, may prove very useful.

Another source of support to those wishing to quit are local stop smoking services. Again, patients may be unaware of the range of services these can provide, or not

actually realise that they exist at all. When discussing this form assistance it is important that the person conducting the intervention be aware of the local service details and systems of referral. This information may change over time and so any information should be checked and updated periodically.

In the case of both pharmacological and local service assistance, it should be born in mind that the purpose of this part of the intervention is to assist by raising awareness of support, and not by forcing uptake of that support. A patient, particularly if they are at a pre-contemplating stage of change, or have very low confidence in their ability to quit, may react badly to having services forced upon them. Rather, such patients may benefit greatly from being given space to consider these options and to access them in their own time.

Group Discussion:

What issues may be important when choosing an NRT product?

This review should cover:

- *Delivery of nicotine (eg - immediate vs slow release)*
- *Social issues (eg – using gum at work, or nasal sprays in social situations)*
- *Financial Costs*

Show trainees examples of products

2.7 Arrange

As the brief intervention draws to an end the focus should shift towards moving the patient on, in some way, towards quitting. By this point, the person conducting the intervention will have a good idea of where the patient is at in terms of thinking about quitting, and this should inform how the intervention is concluded.

2.8

In some cases, the patient may be at the stage where they feel ready to take up the help of specific stop smoking services. This can be offered to the patient in terms of either a referral by the clinician, or in terms of giving the patient the means to contact the service themselves to book an appointment.

Even for the most motivated of patients, the decision to access services is likely to involve some level of anxiety. The services should be presented in a positive way that emphasises their approach and dispels worries of being 'bullied' into quitting. If a decision has been taken to contact a service then briefly checking for sources of anxiety may prove valuable and decrease the likelihood that the patient will change his or her mind later on.

In many cases, however, patients will not reach the stage of deciding to access stop smoking services, or even of trying NRT. In these cases, it is still important to conclude the intervention in a positive way. For example, a patient can be given leaflets referring to services to read through in their own time. They may also be encouraged to speak to their GP or another clinician about smoking next time they have an appointment. Of course, if the basic intervention is forming part of a more intensive intervention (see next section) then the conclusion may focus on what the patient can think about before the next session (eg – how smoking affects their health or who among their family and friends may support them in a quit attempt). Whatever the outcome, it is always worth asking the patient if they have questions before ending an intervention session. Important issues may arise at this late stage that can be dealt with immediately or at a subsequent meeting.

Group Discussion:

What feelings may trainees experience after an intervention?

- Frustration with patient - Concern over own ability - Pessimism over effectiveness of intervention - Concern for patient

Section 3

Intensive Interventions

Session Aim:	To provide trainees with the knowledge and skills essential for the delivery of a four session, intensive intervention.
Learning Outcomes:	A knowledge of the timeline and structure of the intensive intervention. An awareness of the basic principle of motivational interviewing. A knowledge of the importance of basic methods of effective communication, including open questioning and reflection. An understanding of the content of an intensive intervention, including the use of techniques such as typical day narratives, pros and cons exploration and scaling questions.
Learning Activities:	Lecture; Group Discussion
Supporting Materials:	PowerPoint Presentation (RETAD training manual_3.ppt) Handout: Printout of slides with space for notes.

3.1 Intensive Interventions: Evidence Base

While the incorporation of brief smoking cessation interventions into routine clinical care potentially has great value in terms of public health, it is likely that a more intensive approach may represent a more effective framework for intervention.

3.2

In particular, interventions carried out in a hospital setting may benefit greatly from follow up work. This allows patients the time to move towards the point of quitting in their own time. Follow up interventions beyond the point of discharge may also help reinforce the gains made in previous intervention sessions in the patient's natural, home environment.

The findings of a recent review of studies among hospital patients suggests that the use of smoking cessation interventions delivered during the hospitalisation

period that also include follow-up for at least one month post-hospitalisation represented the most effective approach (Rigotti et al., 2003). There was evidence that increasing the intensity of intervention, in particular by increasing the amount of follow-up contact after discharge, is associated with higher rates of cessation.

3.2 The Timeline and Structure of an Intensive Intervention

3.3

The RETAD intensive intervention is designed to be applied flexibly across a range of hospital settings, including both in-patients and out-patients. For in-patients, the intervention sessions cover the period of hospitalisation and extend to around 1 month after discharge.

The intensive intervention begins with the brief intervention session described in the previous section. There is little difference in the format of a brief intervention provided as part of an intensive intervention from that provided as a stand alone intervention. The only variation may arise in the way the session is concluded, in that a brief session delivered as part of intensive intervention will be ended with reference to, and a focus towards, the next session.

The subsequent interventions sessions follow the timeline illustrated below: The first, face to face session will be scheduled for approximately 1 week after the brief session (or earlier if discharge is imminent). After discharge, (or after approximately a fortnight in the case of out-patients), two follow up sessions are delivered over the telephone.

- BRIEF SESSION (5 mins)
- INTENSIVE 1 (20 mins face to face) (1 week after BASIC)
- INTENSIVE 2 (20 mins telephone) (1 week after discharge)
- INTENSIVE 3 (20 mins / telephone) (2/3 days after INT2)

3.3 The Principles of Motivational Interviewing (MI)

3.4

The RETAD intensive intervention draws upon many of the techniques employed in Motivational Interviewing. Motivational Interviewing (MI) evolved from the work done with problem drinkers by Miller in the early 1980's. The basic concepts

outlined by Miller were then developed and applied more generally by Miller and Rollnick in the 1990's along with a more detailed description of the clinical principles underpinning the model. Since then there has been a great deal of research evidence amassed to support the clinical application of Motivational Interviewing across the range of 'problem behaviours' such as alcohol abuse, drug use, and more generally in the field of behaviour change. One of the more recent advances is the application of the model to smoking and smoking cessation interventions.

Miller and Rollnick define Motivational Interviewing as a '*Directive client-centered counselling style for electing behaviour change by helping clients explore and resolve ambivalence*', Miller & Rollnick (1995). In contrast to non-directive counselling with which it shares some characteristics it is more focused and goal-directed. In the case of smoking, the approach is focused on the ultimate goal of abstinence. The role of the advisor is to intentionally examine and explore the smoker's ambivalence to change and to highlight the smoker's ambivalence, and to elicit self-motivating statements.

The true essence of MI cannot be encapsulated in a set of simple instructions or rules. There is the spirit of MI, which is to be distinguished from the techniques employed in the practice of MI. The key points are;

1. *Motivation to change is elicited from the client, and not imposed from without.* Therefore, the use of coercion, persuasion and confrontation are antithetical to the method. MI relies upon the smokers own goals and values to stimulate change
2. *It is the smoker's task, not the practitioners, to articulate and resolve his or her ambivalence.* All addictive behaviours have at their core an approach avoidance conflict. Ambivalence manifests as approach or avoidance, or indulgence versus restraint. Smokers know that smoking is bad but they also enjoy smoking and get personal benefit from the behaviour. It is psychologically reinforcing. The practitioner's task is to

3.5

facilitate the smoker's expression of the two sides to smoking and guide the smoker towards a resolution that triggers change.

3. *Direct persuasion is not an effective method for resolving ambivalence.* Direct and persuasive tactics aimed at getting the smokers to realise the need for change will almost always result in resistance and a reluctance to engage in 'change talk'. Instead, the smoker will become even more entrenched in their pro-smoking, anti-change mindset and this will reduce the likelihood of change.
4. *The counselling style is a quiet and eliciting one.* There is no place for an argumentative approach in MI. This is counterproductive and will lead to smokers feeling angry, frustrated and labelled. The approach in MI may seem slow and passive but an aggressive approach designed to confront the smokers 'denial' or reluctance to change will lead to both parties feeling dissatisfied.
5. *The practitioner is directive in helping the smoker to examine and resolve ambivalence.* The focus in MI is on the assumption that ambivalence or lack of resolve is the main reason why smokers do not change. This is the main obstacle that needs to be overcome before change will occur. The practitioners role is to elicit, clarify and help resolve the smoker's ambivalence to change in a client-centered atmosphere.
6. *The therapeutic relationship is more like a partnership than expert/recipient roles.* It is vital that in the therapeutic relationship between the practitioner and the smoker there is an assumption that the smoker has complete autonomy and responsibility for change. It is not the practitioners job or responsibility to get the smoker to stop smoking. The smoker has a right to change or not to change. The therapist acts as a helper and advisor, allowing the smokers to explore the options for change and come to their own decision to stop smoking when they are ready.

Group Discussion:

How does this approach differ from the one trainees normally adopt with patients? How is it similar?

Issues:

- Do trainees normally 'tell' patients what to do in other contexts?
- Are clinician's usually more 'responsible' for outcome?
- How do trainees feel about relinquishing the 'expert' role?

3.4 Dangerous assumptions

A number of assumptions are counterproductive to the intensive intervention process. These assumptions need to be addressed and eradicated in the mind of the person conducting the intervention. If retained, they may hinder the interaction, and therefore, the effectiveness of the intervention. Additionally, such assumptions are likely to make the intervention a less rewarding experience for the clinician.

3.6

Assumptions that are likely to hinder the interaction include the view that the patient ought and is ready to change. These, particularly the latter, may not be the case, particularly if the patient's life is in upheaval of some kind. These assumptions also imply a more practitioner-centred approach and fail to place the patient's agenda at the forefront.

Another unhelpful assumption would be that the patient's health is a prime motivating factor for him/her. This, again, may simply not be true, particularly in the case of those at pre-contemplator stage regarding quitting smoking. While one may expect that patients using hospital services would have their health at a fairly high place on their agenda, to assume this may be counterproductive.

Finally, an important assumption for anyone delivering these interventions is that, if the patient does not decide to change the behaviour, then the consultation has failed. First, this is not true, as a patient may have moved significantly forward in their readiness to change without actually reaching the point of quitting. Second, such an assumption, if conveyed to the patient, may seriously hinder the efficacy of future sessions in the intervention, or adversely effect smoking cessation work by other agencies with that patient. Third, this assumption places too much pressure on the person conducting the intervention. The clinician should regard his or her task as delivering the intervention to the best of their ability, not as producing behaviour change. Change is, and must remain, the responsibility of the patient alone.

3.5 Communication Skills

3.7

The communication style employed in the RETAD intensive interventions draw upon techniques used in other, person centred counselling methods. Unlike in the brief session, the intensive sessions have less of a fixed agenda. Rather the aim is to facilitate the patient's exploration of their feelings about smoking and smoking cessation. While the intervention is directive, in that there is a desired outcome, the route towards it is not strictly prescribed and very much under the control of the patient.

The rationale behind this approach is that reasons and motivation for change will be far more powerful, and far more likely to result in actual change, if they come from the within the patient. A clinician simply 'telling' a patient why he or she should quit smoking is far less likely to lead to a quit attempt than the patient arriving at those conclusion him or herself.

3.8

Within the communication style employed in the RETAD intervention are a number of techniques, or skills, which may be employed in order to facilitate open discussion. These skills are based on the assumption that it is not enough just to hear what someone is saying, but that we need to actually listen and understand, and convey to the patient that that is indeed what is happening.

The following skills are simple yet powerful tools for effective listening, and if implemented correctly, will make a patient feel that they are being listened to, and greatly enhance exploration of their thoughts and feelings around smoking.

3.5.1 Open Ended Questions

Questions can be divided according to whether their phrasing encourages or hinders the flow of information in an interaction. 'Closed' questions tend to restrict the detail that arises in an interaction since they are questions that only really require a 'yes' or 'no'. 'Open' questions, however, are phrased in a way that demands more than a one word answer, and invites the recipient to expand on an issue.

While seemingly a simple technique, the method of keeping an interaction based upon open ended questions can actually be a difficult skill to master. One helpful guideline to remember is that, while closed ended questions tend to begin with the words 'Do...?', 'Are...?' or 'Is...?', open ended questions are more likely to begin with 'How...? Or 'What...?'

Group Discussion:

Using slide 3.9, ask the group to convert closed questions to open questions. Allow time for alternative answers to be generated for each example.

Notes:

- To aid understanding, ask trainees to answer their own questions with just 'yes' or 'no' to see if it makes sense. If it does, then it was a closed question.

3.9

3.5.2 Summarising

As mentioned earlier, any supportive interaction may be greatly enhanced by conveying to a patient that he or she is really being listened to and understood. One way in which this can be made clear, while also helping the conversation flow,

is the use of summarising. Again, this is a very simple, yet powerful technique that can greatly enhance the delivery of the intensive intervention.

Summarising simply involves the person conducting the intervention reflecting back to the patient what they perceive to be the meaning of what the patient has said. It is more than just repeating back to back what the patient has said in different words. Rather, the aim is to capture the overall meaning of what has been said. This is done at regular, appropriate points in the conversation and, aside from letting the patient know that he or she has been listened to, serves to prompt the patient for more information.

Like open ended questioning, summarising may take some practice before it can be employed fluidly and with confidence. One helpful guideline is to begin by using summary statements that begin with “it sounds like...” or “it seems that...”. Phrasing statements in this way imply that the person conducting the intervention is merely giving his or her perception and not asserting that this is correct.

Group Discussion:

Using slide 3.10, ask the group to summarise the statements one by one. Again, allow time for alternative answers to be generated from different members of the group.

Notes:

- What are the consequences on an incorrect summary, in which one misinterprets the meaning of what the patient has said? Is this necessarily a bad thing?

3.10

3.5.3 Reflecting Emotion

The third communication skill, reflecting emotion, is really just a variation on the previous technique of summarising. The aim of this skill, rather than state one's perception of the meaning of what the patient has said, is to state one's perception of the emotion being conveyed.

Patients will convey many emotions across an intervention session. These will include anger, frustration, guilt, sadness, pride, happiness and anxiety. However, patients may not always express an emotion directly, such as by saying “I feel angry”. Rather, how the patient feels may be conveyed indirectly, both by what they say, and how they say it.

As with summarising, reflecting emotions should be done at regular and appropriate moments within the interaction. Reflective statements may begin with word such as “you sound like you’re feeling...” or “you seem to feeling rather...”. Again, phrasing statements in this way allows for inaccuracy, and implies that the person conducting the intervention is merely giving his or her perception of the patient’s emotion. Indeed, being inaccurate is not necessarily a hindrance to the interaction. Rather it can actually facilitate it at times, in that the patient may clarify how they actually feel, thus reflecting on their internal state further.

Group Discussion:

Using slide 3.11, ask the group to summarise the statements lone by one. Again, allow time for alternative answers to be generated from different members of the group.

Notes:

- What are the consequences on an incorrect summary, in which one misinterprets the meaning of what the patient has said? Is this necessarily a bad thing?

3.11

3.6 Content of the Intensive Intervention Session

The intensive intervention sessions are different from the brief session in that they are far less structured. Rather, the aim is to spend some time (approximately 20 mins) with the patient and interacting with them in a way that allows them to

explore their feeling about smoking and quitting. As the style is intended as patient-centred, the agenda should be allowed to be that of the patient.

However, some direction is needed from the person conducting the intervention. Obviously, the conversation needs to remain focused on the issue of smoking, and only allowed to leave this issue temporarily and if appropriate. Additionally, the interaction should, if possible, flow towards the positive aspects of quitting, and against any misconceptions or negative beliefs that the patient may hold.

A number of techniques, or tools, can be employed within the intensive intervention sessions to facilitate this process (described in the next section). They are designed to be used flexibly, and are to be used by the person conducting the intervention wherever they feel appropriate. Some guidance can be found in the intensive intervention flowcharts (presented after these techniques), which suggest a structure for the incorporation of the various techniques into a complete session.

3.12

While employing these techniques, the focus on communication skill and style should not be lost. Ongoing and appropriate open ended questioning, summarising and reflection will facilitate the interaction, enhance the efficacy of the intervention techniques and help build a good relationship with the patient.

3.6.1 'Typical Day' Narratives

A useful way to begin a first intensive session is to gain some idea of the place of smoking in the life of the patient. How soon after waking does she have her first cigarette? Does she smoke at certain times? Does she smoke a lot in social situations? This is all important information that may be referred to later in the intervention process.

3.13

One way of eliciting this information is to ask the patient about their 'typical day' and how smoking fits into it. Aside from eliciting the above information, it will also reveal a lot about the patient's life and the people around them, again important information that can be used subsequently.

This technique has the advantage that issues will emerge naturally, and not as a result of a lot of questioning on the part of the person conducting the intervention. One disadvantage is that it requires the patient to be fairly confident about talking to you. Anxious or less forthcoming patients may require a certain amount of prompting.

In either case, it is important to remember the communication skills described above. The patient should not be left to talk without any response from the person conducting the intervention. Rather, open-ended questions, summarising and reflection should be used regularly and at appropriate times.

3.6.2 Exploring Pros and Cons

3.14

This technique encourages the patient to consider what they like, and what they don't like, about their smoking. Since smoking quickly becomes a very automatic behaviour, that most people do without thinking, this is something they may well have never considered in any detail before. By highlighting and asking the patient to explore the ambivalence they have concerning being a smoker this technique can help move the patient forward in their thoughts about quitting.

Since the desired outcome is a quit attempt, it makes sense for the person conducting the intervention to guide the focus of the interaction more towards the disadvantages, or the 'cons', of smoking. One way to increase the saliency of the cons is to address them *after* the pros as opposed to before. This is simply because the side of the argument addressed last is more likely to remain prominent in the mind of the patient after the intervention. Exploring the cons second also increases the likelihood that they will counteract some of the stated pros. For example, a patient may list as an advantage that smoking helps them relax in social situations. However, they may subsequently reflect that their smoking sometimes upsets friends or family and can be the cause of conflict. Similarly, a patient may see smoking as helping them stay physically attractive by keeping their weight down. However, they may also acknowledge that smoking can age skin, stain teeth and produce an unattractive smell on clothes.

This technique can be extended to exploring the pros and cons of quitting rather than smoking. By doing this, the patient is encouraged to consider what they fear about giving up smoking, and to balance that against the benefits of making this step. Of course, if the technique is applied in this way, the order of the considerations should change. Since the desirable outcome is quitting, then the pros of quitting should come after the disadvantages are considered.

Group Discussion:

**What may patients list as the pros and the cons of smoking?
And the pros and cons of quitting?**

Issues may include:

- Pros of smoking: relaxation, controls anxiety, sociable, alleviates boredom
- Cons of smoking: health impact, financial costs, anti-social
- Cons of quitting: withdrawal, weight gain, fear of change
- Pros of quitting: improved health, save money, sense of achievement

3.6.3 Assessing Readiness to Change

Before anyone is ready to make any difficult change in their life it may be they need to be fairly sure of two things. First, they must feel that making the change is important and worth the effort. Second, they must feel confident that they will be able to make the change successfully. Therefore, readiness to quit smoking can be seen as a function of a patient's perceived importance of, and their perceived confidence in, quitting. When both are high, change becomes likely.

3.15

Importance and confidence can be assessed quickly and easily within an intensive intervention session. One way is to invite the patient to give ratings of both on a ten point scale, or alternatively, as a percentage. For example, the patient could be asked:

3.16

“I’m not sure exactly how you feel about stopping smoking. How important is it to you personally to quit? If 0 was “not important” and 10 was “very important”, what number would you give your self?”

“Also, if you did try to quit, say tomorrow, how confident would you be that you would succeed? If 0 was “not at all confident” and 10 was “very confident” how would you rate your self?”

Assessing importance and confidence helps the intervention in a number of ways. For the person conducting the intervention, it gives an idea of how far the patient needs to go before being ready to quit, as well as which aspect may require more attention (ie – importance or confidence). For the patient, it allows them to explore their own feelings and identify, maybe for the first time, the barriers against them giving up smoking. In addition, these scaling questions can be used to elicit motivational statements from the patient. This is discussed in the next section.

3.6.4 Eliciting Motivational Statements

One can only motivate a person to make a change to a very limited degree by ‘telling’ them that such a change is important, or that it is achievable. As mentioned earlier, ideas that arise within the patient themselves will be far more powerful in motivating change. This is particular true in the case of importance and confidence regarding quitting smoking.

3.17

Therefore, one aim within the intensive intervention is elicit ‘motivational statements’ from the patient. That is, to encourage them to come up positive assertions from their own minds regarding the importance of quitting, or regarding their confidence in being able to do it.

This can be done by following up the previous scaling questions by asking the patient why they did not rate themselves as lower, say in confidence. If, for example, a patient rated themselves at ‘4’ in confidence, they could be asked why they didn’t rate down at 1 or 2. This encourages the patient to reflect openly on why they do have at least confidence in their ability to quit. The reason may be that they have managed to give up before for a significant amount of time, or that

they have a supportive partner who has helped them achieve difficult things in life on previous occasions.

Eliciting motivational statements can be taken further, by then asking the patient to consider circumstances that would make them rate importance or confidence higher. For example, if a patient rated the importance of quitting as '6', they could be asked to reflect on what would have to change for them to rate up at 9 or 10. Their answer may include changes in health, such as a worsening of their asthma. At this point the person conducting the intervention may advise the patient that postponing quitting until symptoms worsen may make a recovery far more difficult, since a lot of damage has already been done by this point.

Group Discussion:

What may patients list as the reasons for not rating importance or confidence lower than they did?

Importance:

- "Smoking is killing me"
- "I'm more aware of the risks of smoking than I used to be"
- "I'm tired of being an addict, I want to regain control"

Confidence:

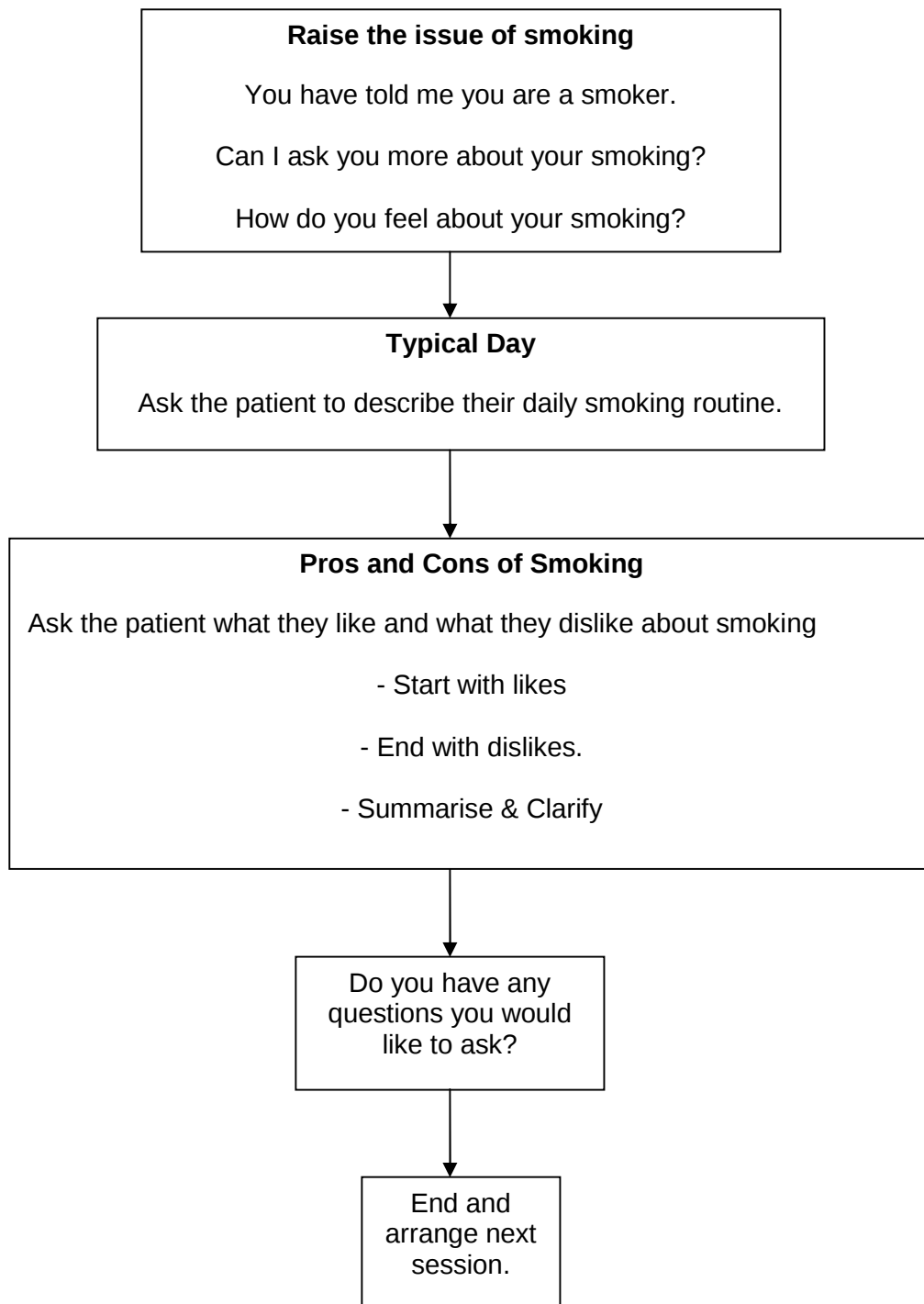
- "I've always had good will power; I'm a very determined person"
- "I've done it before, I can do it again"
- "I have people around me who will be supportive"

3.7 Intensive Intervention Flow Charts

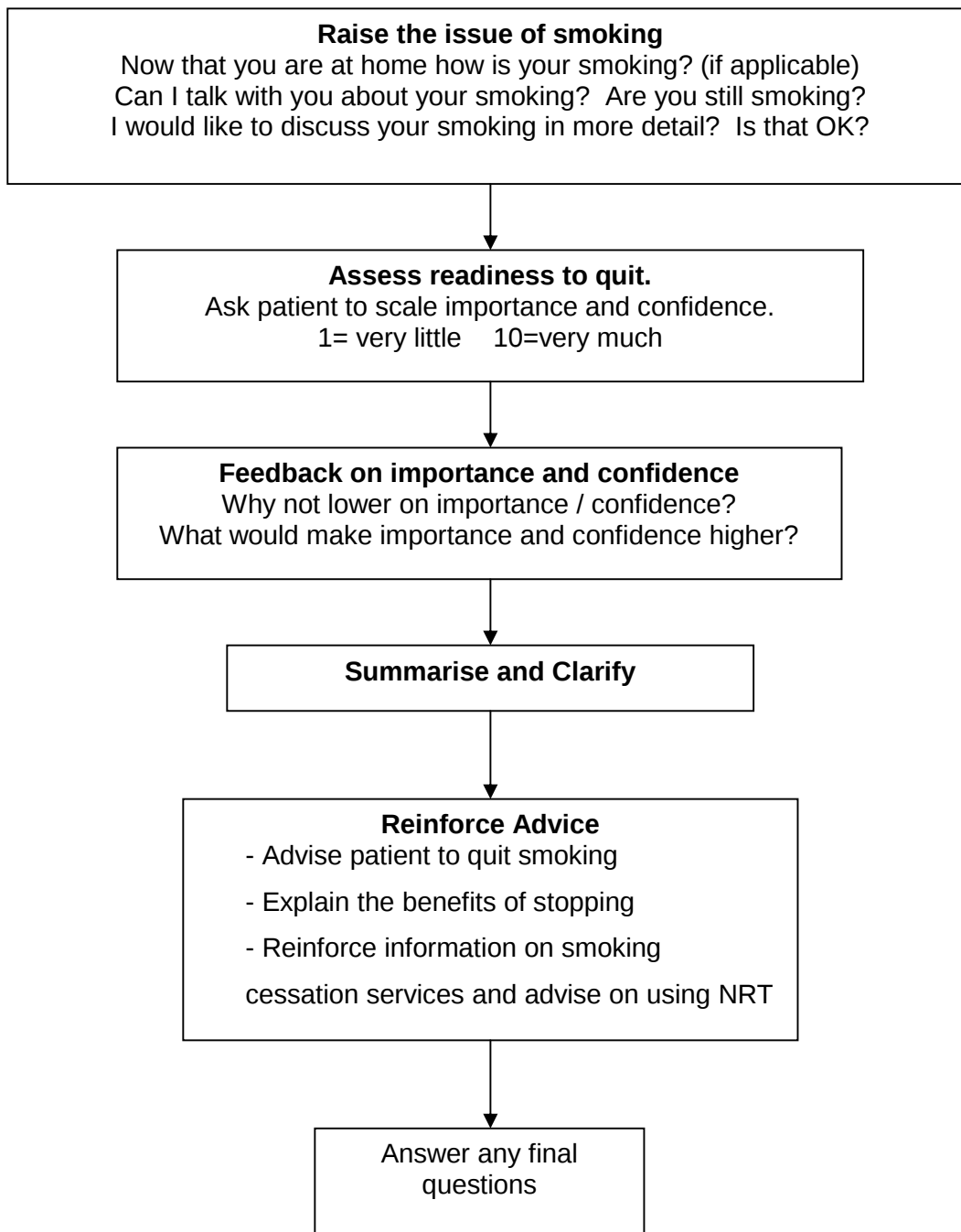
The following pages contain a suggested structure for the intensive intervention. These flowcharts were designed in a way that incorporates the various techniques into the intervention in a fluid and instinctive way. As mentioned earlier, these flow charts are intended as a guide only. The nature of the intensive intervention, and its patient-centred style, requires a flexible approach that can accommodate the wide variety of patients, circumstances and outcomes that a clinician conducting the interventions will inevitably encounter.

3.18

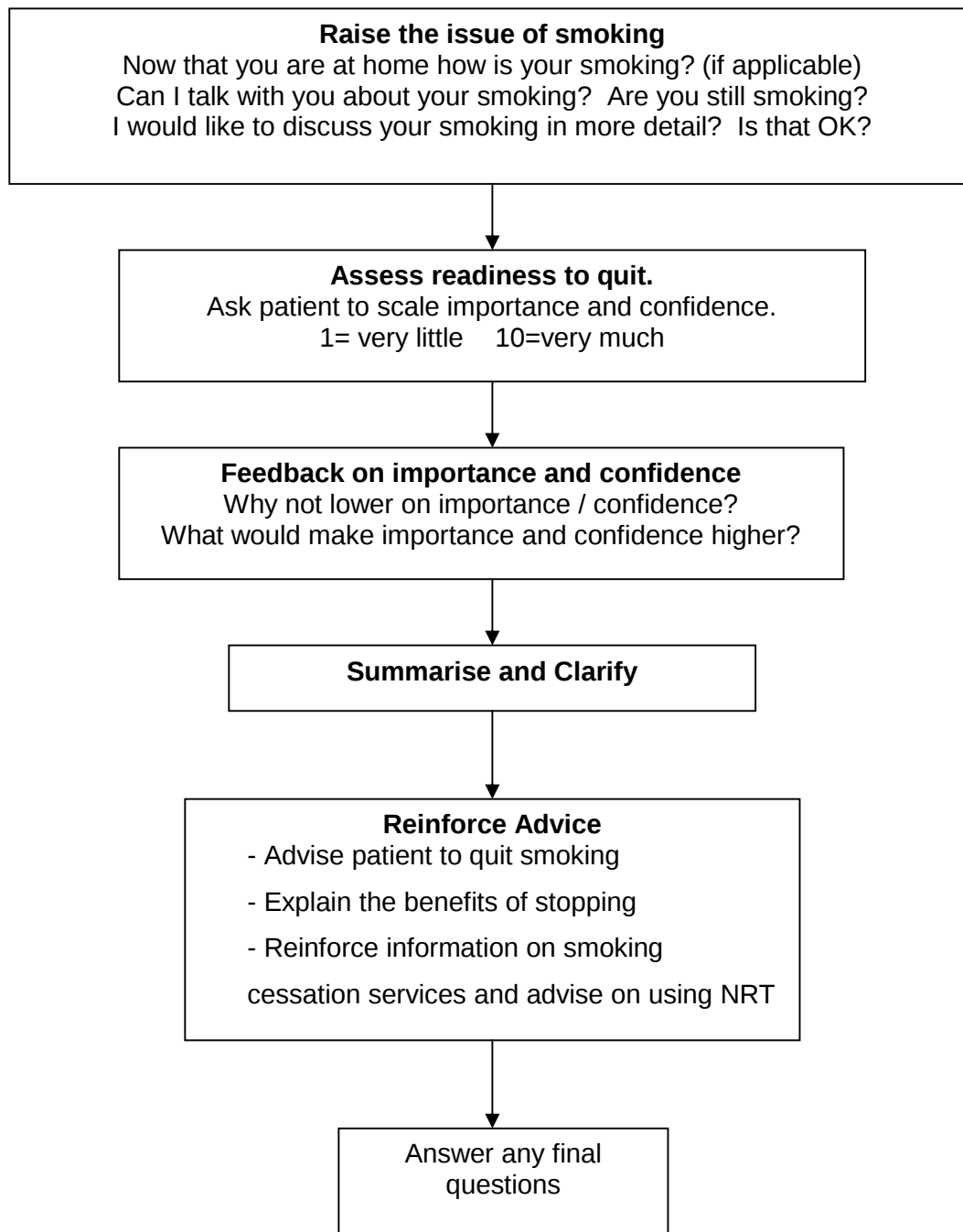
Intensive intervention flow chart Session One



Intensive intervention: Two



Intensive intervention: Three



Section 4

Intervention Delivery

Session Aim:	To develop the practical skills necessary for the delivery of both brief and intensive interventions.
Learning Outcomes:	An enhanced awareness of good and poor intervention delivery styles. The ability to progress through an intervention session fluidly. The ability to apply communication skills such as open questioning, summarising and emotional reflection. The ability to employ intervention techniques in a way that elicits information and motivational statements from a patient. A knowledge of how to apply the intervention under challenging circumstances, such as in the presence of an indifferent or aggressive patient. An awareness of how sessions and interventions should be concluded.
Learning Activities:	Lecture; Group Discussion; Role Play
Supporting Materials:	Videotape: "Health Behaviour Change – A Selection of Strategies: An Aid for Trainers" Handout: Intervention Guide

4.1 Intervention Style

The videotape "Health Behaviour Change – A Selection of Strategies: An Aid for Trainers" contains a number of examples of intervention delivery. This provides a useful resources for demonstrating both good and bad styles of communication as well as feedback from the 'patients' receiving the intervention.

4.1.1 Aggressive and Demanding Style

Segment 2 provides an example of a clinician talking to a patient about smoking cessation. The style is aggressive and demanding, and provides an example of

the use and consequences of direct persuasion. The style is very clinician-centred in that the patient's agenda is not explored to any degree.



SEGMENT 2
(04:38)

Group Discussion:

What mistakes did the clinician make?

May include:

- Aggressive style – made patient defensive
- Followed own agenda – ignored patient agenda
- Failed to explore for patient's perspective on his smoking
- Lost focus on issue of smoking (moved to drinking & diet)

Group Discussion:

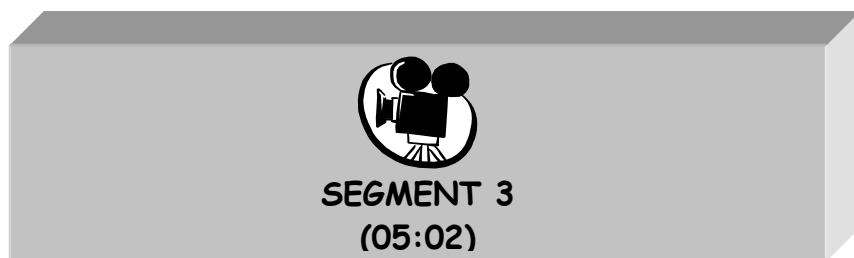
How will the patient have felt during, and after the consultation? What would be the likely outcome?

Feelings:

- Anxious
- Defensive
- Angry

Outcomes:

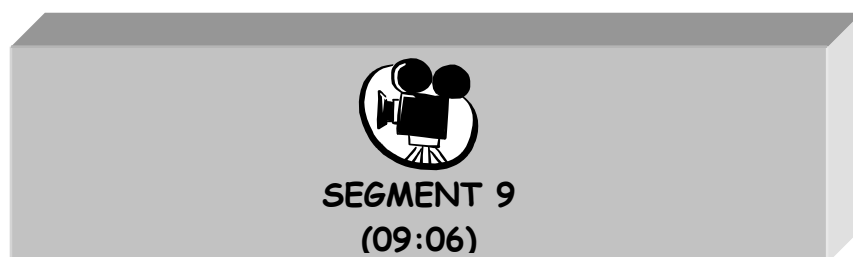
- No change in smoking behaviour
- Maybe become more defensive of smoking – more resistant to change
- May not consult doctor again



4.1.2 Person Centred Style

A more appropriate, person centred style is demonstrated in segment 9 on the videotape. The clinician is concerned with, and explores, the patient's agenda and perspective on her smoking.

This segment demonstrates a good communication style in conjunction with the application of the importance and confidence scaling techniques. The consultation is a good illustration of how intervention techniques can be introduced into an interaction in a natural, conversational way.



4.2 Employing the Brief Intervention

A flowchart for the brief intervention is presented earlier in the manual. As already discussed, this intervention follows a clear structure according to a 'Four A's' approach. The stages are Assess, Advise, Assist and Arrange.

While the style should be fairly directive, the aim is to still allow the patient space to reflect on the issue of smoking and give feedback on their attitudes and opinions towards quitting. Therefore, while less so than in the intensive

intervention, open questioning, summarising and reflection do have their place in an effective brief intervention.



Role Play (10 mins)

Brief Intervention with trainer as 'clinician' and trainee as 'patient'.

Discussion:

- How did the 'patient' feel during the intervention?
- To what extent did the 'clinician' use a person centred style



Role Play (5 mins per trainee)

Brief Intervention with trainee as 'clinician' and trainer as 'patient'.

Notes:

- As many trainees as possible should have the opportunity to try the intervention
 - The 'patient' should adopt a variety of styles (eg – chatty, shy, etc)
- Second trainer should interrupt with feedback when salient points arise

4.3 Intensive Intervention (Face to Face Session)

An important aim of the first intensive session is to build up a good relationship with the patient in which the latter feels able to explore ideas and feeling freely. Effective communication is therefore essential, and a particular focus should be placed upon communication skills such as open questioning, summarising and reflecting emotions.

The actual structure of the session is designed to be flexible. One recommendation, however, is that the session cover at least two of the techniques discussed in the previous section. A good starting point may often prove to be the 'typical day' narrative, followed up by a discussion of the pros and cons of smoking.



Role Play (30 mins)

Intensive Intervention with trainer as 'clinician' and trainee as 'patient'.

Discussion:

- How did the 'patient' feel during the intervention?
- To what extent did the 'clinician' use a person centred style?
- Where the techniques introduced at appropriate times?



Role Play: 'Relay' Method (30 mins)

Intensive Intervention with trainee as 'clinician' and trainer as 'patient'.

Notes:

Each trainee spends a few mins talking to the 'patient', after which the next trainee takes over from where the conversation left off. The role play should cover one whole intensive session with each trainee having some time as the clinician. The second trainer may stop the interaction and offer feedback where appropriate.

4.4 Intensive Intervention (Telephone Sessions)

Face to face communication has many advantages to talking over the telephone. Maybe most importantly, a telephone interaction loses a lot of non-verbal communication, which can be all important when expressing feeling and emotions. Pauses in the conversation may be difficult to interpret, in that it may unclear as to whether the patient is taking time to think, or whether the conversation has ground to a halt. Additionally, telephone conversations offer a lot less control over the patient's environment. That is, while a face to face session can be set up in a private room where things are unlikely to be disturbed, calling a patient at home involves the possibility that any number of things may happen to disrupt the interaction at the patient's end (eg – family member entering room, doorbell ringing, etc).

These disadvantages are faced in the second and third intensive sessions, which are conducted over the telephone. The person conducting the intervention needs to retain a particular focus on the communication skills already discussed, as well as listening carefully to the patient's tone of voice for clues to their feelings and emotions.

One way to pre-empt the problem of disturbance at the patient's end is to pre-arrange the telephone call. At the time of arranging the call, the patient can be asked about times when they are less likely to be disturbed, and whether they could set aside 20 or so minutes to take the call. They can also be asked if there is a quiet area of their home that they could take the call (eg – a bedroom rather than the main hallway).

One advantage of the telephone session is that the person conducting the intervention is able to take more extensive notes on the interaction. This is because, unlike in the face to face sessions, there is no need to maintain good eye contact or be aware of their body language. Note taking can help the person conducting the intervention summarise and clarify information such as pros and cons, as well as provide a useful resource for subsequent sessions.



Role Play: 'Relay' Method (30 mins)

Intensive Telephone Intervention - trainee as 'clinician' and trainer as 'patient'.

Notes:

As before, each trainee spends a few mins talking to the 'patient', after which the next trainee takes over from where the conversation left off. The 'patient' should be turned away from the trainees so as to exclude eye contact and other non-verbal communication. The 'patient' may pretend to be interrupted at some point during the interaction (by someone coming to the front door, or by a child demanding attention).

4.5 Challenging Scenarios

In real life, we can't expect patients to behave exactly as we would like them to. On most occasions, patients won't respond to questions with thoughtful enthusiasm, and exhibit a noticeable sense of revelation as we guide them through the intervention! Rather, they will demonstrate a wide range of characteristics and attitudes, and these may not always make life easy for the person conducting the intervention.

4.5.1 Countering indifference

One common response of patients to behaviour change interventions is indifference. To varying degrees, patients may give the impression that they neither care about the issue of smoking or the challenge of quitting. They may be unresponsive within the interaction, giving only short or one word answers to questions, or being reluctant to fully explore issues that they are presented with. The source of such an unresponsive style may vary. In some case, the patient may have lost enthusiasm for the intervention, and be keen to get it over and done with. In other cases, their quietness may reflect anxiety or shyness.

The person conducting the intervention may be able to improve the interaction by focusing on open questioning, and drawing information out of the patient that may be expanded upon. If the patient remains unresponsive then this, itself, may be

something that the person conducting the intervention can highlight and reflect back. For example, one may want to say something like; “you seem reluctant to talk about this today; why may that be?” or “can you tell me how you feel about these sessions we’re having?”

Of course, if a patient really does not want to interact on a particular occasion then it is unfair on both them and the person conducting the intervention to attempt to force the issue. Trainees should always bear in mind the assumptions discussed in the first section, and remember that responsibility to change must be, and remain, firmly with the patient.



**Role Play: 'Relay' Method
(30 mins)**

Intensive Intervention - trainee as 'clinician' and trainer as 'patient'.

Notes:

As before, each trainee spends a few mins talking to the 'patient', after which the next trainee takes over from where the conversation left off. The 'patient', in this exercise, should be unresponsive and seem negative towards the interaction. If a trainee uses appropriate techniques the 'patient' may 'reward' this with more responsiveness.

4.5.2 Aggressive Behaviour

In a few cases one may encounter a patient who seems hostile towards the intervention. He or she may seem resentful. Maybe because they have lost enthusiasm since agreeing to attend the sessions, or maybe because they have been 'pushed' into the intervention by their GP or consultant physician.

A negative attitude to the intervention may manifest itself in an unresponsive, indifferent manner, which may be addressed in the ways discussed above. Alternatively, a patient may become argumentative and / or aggressive during an interaction.

The main thing to avoid in such a situation is being drawn into a debate or argument. 'Locking horns' with a patient over an issue is likely to be counter-productive to the aims of the intervention, as well as stressful for the person conducting the intervention. Rather, the aim should be to 'roll' with resistance and explore with the patient why they feel so resentful towards the intervention, quitting smoking, or both. The person conducting the intervention may also want to express how they perceive the situation, and in particular, reflect the patient's emotions; "you seem really angry" or "you sound like you're unhappy at being asked to talk about these things".

As with indifference, aggression can only be countered to a certain extent. The person conducting the intervention must be clear that there is a point at which a patient's aggression becomes inappropriate and maybe look to terminate the session. This should be done as calmly as possible, and if appropriate, leaving the possibility of future sessions open to the patient. For example, one may say "I can see that you're upset and maybe today is not the best time for us to chat about these things. Maybe we can end here and meet again some time soon?"



**Role Play: 'Relay' Method
(30 mins)**

Intensive Intervention - trainee as 'clinician' and trainer as 'patient'.

Notes:

As before, each trainee spends a few mins talking to the 'patient', after which the next trainee takes over from where the conversation left off. The 'patient', in this exercise, should be negative towards the interaction, and display an argumentative and mildly aggressive manner. If a trainee uses appropriate techniques the 'patient' may 'reward' this with more responsiveness.

4.6 Ending an Intervention

As with the brief intervention, the aim at the end of the final intensive session should be to move the patient on in the quitting process. By the point, the person conducting the intervention should have a good idea about the patient's attitudes to quitting, and maybe seeking more help to do so. If appropriate, therefore, the possibility of a referral to a stop smoking service may be discussed. Or maybe the patient would prefer to take away leaflets with details of these services.

Even if the patient has made little progress towards quitting during the intervention, the aim should still be to round things off in a positive manner. The person conducting the intervention may have noticed some positive changes in the patient's thinking, even if this is only that they have considered the issue of their smoking and quitting in more depth than they had before. Patients may have a better understanding of why they smoke and why they are not ready to quit. This can be highlighted and the session may be concluded by informing the patient that they may always approach their GP or other physician if they want to consider quitting in the future.

4.7 Paired Exercises



Role Play: Paired Exercises

Intensive Intervention - trainees as both 'clinician' and 'patient'.

Notes:

Any remaining time before concluding the training session should be spent by asking trainees to pair up and practice the interventions with their partner. Trainers should circulate within the group, listening in and offering feedback. An emphasis should be placed at this final stage on positive feedback, and highlighting what trainees are doing well. This will serve to boost confidence before trainees apply their skills in a real life setting.

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Web Based Resources

The Department of Health's '[Don't give up giving up](http://www.givingupsmoking.co.uk/)' campaign was launched in December 1999. The website has links to the NHS Smoking Helpline (0800 169 0 169), local stop smoking services and a lots of health information & resources. -

<http://www.givingupsmoking.co.uk/>

Action on Smoking & Health ([ASH](http://www.ash.org.uk/)) is a campaigning public health charity. They are a great source of leaflets, posters, images and presentations all geared to educating people against smoking.

<http://www.ash.org.uk/>

[QUIT](http://www.quit.org.uk/) is an independent charity whose website offers a wealth advice and support for those wishing to give up smoking. You can also phone their free 'Quitline' at any time for confidential help and advice (0800 00 22 00).

<http://www.quit.org.uk/>

Course Feedback Questionnaire

The RETAD team rely upon feedback from those implementing this training programme. Please take some time to complete the following questionnaire and return it to us at the address below.

About You

Organisation _____

Contact Person _____

Address _____

Telephone _____

Email _____

Type of Service Provided (circle all that apply):

- | | | |
|-----------------------------|------------------------|----------------|
| - NHS Trust | - Medical | - Nursing |
| - Psychology / Counselling | - Research / Education | - Youth Work |
| - Smoking Cessation Service | - Mental Health | - Primary Care |

Please provide a short description of the service you provide:

Trainees

Who are your intended recipients of the training programme (circle all that apply):

- | | | |
|----------------------------------|---------------------------|-----------------|
| - Nurses | - Medical Practitioners | - Counsellors |
| - Social Workers / Care Managers | - Occupational Therapists | - Youth Work |
| - Smoking Cessation Workers | - Community Workers | - Psychologists |
| - Other _____ | | |

Intervention Recipients

Who are the intended recipients of the intervention (circle all that apply):

- Medical Patients
- Surgical Patients
- Elderly
- Mental Health Patients
- GP Patients
- Young People
- Patients in Hospital
- Out-patients
- Other _____

Delivery of Training

How frequently do you run training programmes? _____

How many trainees do you hope to train in the next 12 months? _____

How many trainees are taught in each group? (average) _____

Where do you intend to carry out training sessions (circle all that apply):

- Hospital Site
- Out patient clinic
- Smoking Clinic
- Community Mental Health Team
- GP Surgery
- University / College
- Other _____

Is training done across one full day? -yes -no

If no, over how many sessions (and hours) do you spread the training? _____

Training Evaluation

Please rate the extent to which the following aspects of the training programme met your requirements: Please use a scale from 1 to 10, with 1 being requirements not at all met, and 10 being requirements completely met.

- Background Issues

- Smoking & Health _____
- Pharmacological Treatments _____
- Psychological treatments _____

- Practical skills and techniques

- Four A's Approach _____
- Communication Skills _____
- Motivational Interviewing Techniques _____

- Group Discussions _____

- Role Play Exercises _____

Resources

- Handouts _____
- Intervention Guide _____
- PowerPoint Presentations _____
- Video _____
- Trainee Questionnaire _____

—— Your Comments ——

Please let us have any other feedback you may have on the training programme:

—— Return Address ——

Please return this completed questionnaire to:

**International Centre for Drug Policy
St George's, University of London
Cranmer Terrace
London SW17 0RE**